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IN THE

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, GINA DUNNING, Director of Regulation and Licensure of the Nebraska Department of Health and Human Services, and CHARLES ANDREWS, M.D., Chief Medical Officer of the State of Nebraska,

Petitioners,

v.

LEROY H. CARHART, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF PLANNED PARENTHOOD OF WISCONSIN, FREDERIK F. BROEKHUIZEN, M.D., GARY T. PROHASKA, M.D., GAVIN JACOBSON, M.D., NEVILLE SENDER, M.D. AND THE PLANNED PARENTHOOD FEDERATION OF AMERICA, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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DESCRIPTION AND INTEREST OF *AMICI*[1]

Amici Planned Parenthood of Wisconsin, Frederik F. Broekhuizen, M.D., Gary T. Prohaska, M.D., Gavin Jacobson, M.D., and Neville Sender, M.D. are plaintiffs in *Planned Parenthood of Wisconsin, et al. v. James E. Doyle, et al.* (*Doyle*), 44 F. Supp. 2d 975 (W.D. Wis. 1999), *vacated by Hope Clinic v. Ryan* (*Hope*), 195 F.3d 857 (7th Cir. 1999) (*en banc*), *stayed*, No. 99-A428 (Stevens, Circuit Justice Nov. 30, 1999), *pets. for cert. filed*, 68 U.S.L.W. 3461 (U.S. Jan. 10, 1999) (Nos. 99-1156) & 68 U.S.L.W. 3480 (U.S. Jan. 14, 1999) (No. 99-1177). The Seventh Circuit's decision in *Hope*, upholding bans on so-called "partial-birth" abortion from Wisconsin and Illinois, conflicts with the ruling of the Eighth Circuit — at issue here — striking down a similar Nebraska law. *Hope* contains an incomplete and misleading discussion of the factual record in *Doyle* pertaining to the question of the maternal health benefits of the dilation and extraction (D&X) method of abortion. The outcome of *Doyle* could be determined by the decision in this case; thus, these *amici* have an interest in assuring that a complete and accurate discussion of the *Doyle* record is available to this Court.

Amicus Planned Parenthood Federation of America (PPFA), a not-for-profit corporation organized in 1922, is the leading national voluntary health organization in the field of family planning. Currently, PPFA has 132 affiliates

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1. Pursuant to Sup. Ct . R. 37.6, *amici* state that no counsel for a party authored the brief, in whole or part, and no person or entity, other than the *amici*, made a monetary contribution to the preparation or submission of the brief. Pursuant to Sup. Ct. R. 37.3(a), the parties have consented to the filing of this brief. Letters of consent are being filed with the Court.

in 47 states and the District of Columbia, operating approximately 875 health centers. In addition, in many states, Planned Parenthood affiliates have separate organizations that provide them with public affairs and lobbying support at the state level. PPFA submits this brief on its own behalf, on behalf of its affiliates, and on behalf of the state public affairs offices. Many Planned Parenthood affiliates provide abortions that would be prohibited by "partial-birth" abortion statutes, and many of those affiliates have been plaintiffs in challenges to "partial-birth" abortion statutes enacted in other states. The decision in this case will also affect the outcome of many of the other pending challenges to "partial-birth" abortion statutes; thus PPFA and its affiliates have an interest in assuring that a complete and accurate discussion of the *Doyle* record is available to this Court.

SUMMARY OF ARGUMENT

The third section of the majority decision in *Hope* assumed that the Illinois and Wisconsin statutes could be construed to define precisely, and only ban, the D&X method of abortion.[2] Proceeding on that assumption, *Hope* addressed

2. As this Court is aware, *Hope* found that there were possible narrowing constructions of the Wisconsin and Illinois statutes that, in the view of the *Hope* majority, would have limited application of the statutes to a distinct method of abortion, the D&X. *Hope* directed that the statutes be allowed to go into effect subject to "precautionary injunctions." These "precautionary injunctions" were supposed to protect the ability of physicians in Wisconsin and Illinois to provide what *Hope* characterized as "normal" dilation and evacuation (D&E) abortions, while the state courts — through a series of what would have amounted to "test" prosecutions — attempted to define the boundary between "normal" abortions and the D&X.

(Cont'd)

the question of whether states could constitutionally ban the D&X, even pre-viability, and even without an exception to allow the D&X when it would preserve the woman's health. In addressing this question, *Hope* discussed the medical evidence adduced at the *Doyle* trial,[3] and purported to

Amici dispute whether "partial-birth" abortion statutes can be construed narrowly. However, we do not address that issue here because it will be addressed fully in the respondent's brief. *Amici* also dispute whether *Hope's* "precautionary injunction" invention was legally permissible or feasible in reality, given that the D&X is not really a distinct procedure, but rather is a variant or modified approach to the D&E. *See infra* at 7. The impracticality and impermissibility of the precautionary injunction is particularly dramatic in *Doyle*, because the Wisconsin statute carries a penalty of mandatory life imprisonment. *Hope*, at 889 (dissent). *See also Planned Parenthood v. Doyle Pet. for Cert.* ("*Doyle Pet. for Cert.*"), No. 99-1156 at 20-23 (docketed Jan. 10, 1999). However, since there is no precedent for such an injunction, and petitioner has not argued for such an injunction, *amici* will not address that issue here.

3. The *Hope* majority ignored the findings made by the district judge in the Illinois case, stating only that none of the plaintiffs there use the D&X or assert a desire to do so. 195 F.3d at 871. Ignoring the district court findings was not only legally wrong, *see Anderson v. Bessemer City North Carolina*, 470 U.S. 564 (1985), and *Hope*, 195 F.3d at 883 (Posner, C.J., dissenting), but also a way of avoiding inconvenient facts. The Illinois district court made findings describing the health and safety advantages of intact procedures, *Hope Clinic v. Ryan*, 995 F. Supp. 847, 857-61 (N.D. Ill. 1998), and two of the Illinois plaintiff-physicians attested that they personally had performed numerous abortions in which they had partially vaginally delivered an intact or largely intact and living fetus. *Hope Cert. Pet. App.*, No. 99-1152, at 153-54, ¶ 3; 190-92, ¶¶ 27-33. Moreover, one of the Illinois plaintiff-physicians uses the D&X method defined in the ACOG Policy Statement, *see infra* at 9, when medically appropriate, *Hope Cert. Pet. App.*,

(Cont'd)

evaluate that evidence under applicable constitutional standards.

In doing so, *Hope* significantly mischaracterized the medical evidence adduced in *Doyle*, and misstated the applicable constitutional standard. *Amici* submit this brief solely to address these two aspects of *Hope*. We do so, first, to provide this Court with a complete and accurate discussion of the medical evidence in *Doyle*, because this evidence demonstrates not only that there is no maternal health interest that would justify banning the D&X, but that the D&X is, for many women, a medically appropriate abortion method; and, second, to highlight *Hope*'s misstatement of the legal standard to be applied to these facts.[4]

(Cont'd)
No. 99-1152, at 136-38, ¶¶ 5-7, and another performs variants on that method, *Hope Cert. Pet. App.*, No. 99-1152, at 175-78, ¶ 3 (describing use of intact procedure for woman with leukemia-caused low platelet count in order to minimize risk of cervical laceration or uterine perforation).

4. *Amici* note that *Hope* found an interest in "moral considerations" sufficient to justify bans on "partial-birth" abortions. *Hope*, 195 F.3d at 875. Such an interest has never been sufficient to support a regulation of any constitutional right, and has been rejected as a legitimate interest for regulating abortion. *Doyle Pet. for Cert.* at 28. As petitioner has not asserted such an interest in this case, *amici* will not address that aspect of *Hope*.

ARGUMENT

THE RECORD BEFORE THE SEVENTH CIRCUIT DEMONSTRATES THAT THE D&X IS OFTEN THE SAFEST ABORTION APPROACH; THE RECORD DOES NOT DEMONSTRATE THAT A BAN ON THE D&X SERVES AN INTEREST IN MATERNAL HEALTH

Hope characterizes the D&X procedure as a "marginal" procedure, *Hope*, 195 F.3d at 874, that "lacks demonstrable health benefits," and "is never necessary from the perspective of the woman's health." *Id.* at 872. Further, *Hope* asserts that these conclusions were "not a seriously contested issue. None of the plaintiff physicians in [*Doyle*] testified to the contrary." *Id.*

Based on this characterization of the record, the Seventh Circuit ruled that "when state law offers many safe options [to obtain a pre-viability abortion] the regulation of an additional option does not produce an undue burden," *id.* at 871, even if the regulation lacks an exception to protect the woman's health because the requirement of such an exception is not "a universal rule." *Id.* The court in *Hope* concluded that "partial birth abortion laws do not pose hazards to maternal health," *id.* at 873, and that judicial interference with these laws "cannot be justified on the ground that the D&X procedure is necessary to protect women's health." *Id.*

Hope significantly mischaracterizes the facts developed at trial in *Doyle*, and misstates the applicable legal standard.

1. The Trial Record Demonstrates That the D&X Is Safer For Some Women.

The record developed in the district court contains an extensive stipulation of facts. *App.*[5] 438-460. In addition, five physicians testified for plaintiffs. They were the Chairman of Obstetrics & Gynecology at the Boston University School of Medicine and Director of Obstetrics & Gynecology at Boston Medical Center (Dr. Stubblefield), a Professor and past-Chair of the Department of Obstetrics and Gynecology at the University of Wisconsin Medical School's Clinical Campus (plaintiff Dr. Broekhuizen), the physician generally regarded as the most experienced practitioner of the D&X approach (Dr. Haskell), and two physicians (plaintiffs Dr. Christensen and Dr. Smith) who regularly provide abortions in outpatient clinics.

The stipulation establishes that during the first trimester, physicians use a method of abortion that primarily relies on suction to evacuate the uterus. *Id.* 443-44, ¶ 27. After the first trimester, physicians commonly use the dilation and evacuation (D&E) method, which involves grasping and extracting the fetus, and frequently involves dismemberment of the fetus as it is extracted. *Id.* 445, ¶¶ 35-37.[6] The

5. Citations to "App." refer to the Lodging Appendix filed with this brief.

6. We note that the Seventh Circuit's descriptions of the D&E are inconsistent on the question of where the dismemberment of the fetus occurs. In one place the opinion notes that "physicians performing a D&E sometimes do not complete the dismemberment inside the uterus, and some fear that this could lead the procedure to be characterized as a partial delivery under the statute." (Cont'd)

alternative method of abortion in the later second trimester is induction, an in-patient procedure that induces labor to cause the woman to expel the fetus. *App.* 451-52, ¶¶ 72-77.

During some D&Es, depending on the gestational age and size of the fetus and the response of the woman's cervix to the dilation process, the physician will extract the fetus entirely intact, or extract the fetus intact until the skull lodges at the cervix. In the latter situation, the physician will collapse or crush the skull to complete the delivery. *App.* 446-47, ¶¶ 42-46. These abortions could be deemed D&X abortions. The record is clear, however, that the medical profession regards the D&X as a variant — or one approach on a continuum of approaches — of the D&E; that there is no "codified" definition of D&X; and that physicians have varying understandings of exactly what constitutes a D&X. *App.* 334. *See also App.* 77, 131, 328-29. *Compare App.* 447, ¶ 47; 448-50, ¶¶ 62-65.

The stipulation also establishes that, regardless of method, physicians endeavor to conclude an abortion as quickly as possible; and that they attempt to minimize both the number of times and the distance instruments are inserted into the woman's uterus. These goals minimize time under anesthesia, loss of blood during the procedure, and the risk of cervical or uterine lacerations. *App.* 442, ¶ 21.

The witnesses explained that after approximately 18-20 weeks of pregnancy, dismemberment of the fetus becomes

(Cont'd)
Hope, 195 F.3d at 863. Elsewhere it remarks that during a D&E the physician "dismembers the fetus inside the uterus. . . ." *Id.* at 861. The latter statement is unsupported by the record and is medically inaccurate. The record shows that frequently the portion of the fetus to be disattached will be outside of the uterus before it is disattached. *App.* 24-25, 98-99, 127-28, 370.

more difficult and potentially traumatic to the woman because the fetus is larger, with stronger ligaments and harder bones. *App.* 10, 105, 346-47. In these situations, the D&X approach, which emphasizes attempting to extract the fetus intact, minimizes the risk of uterine or cervical lacerations, *App.* 10, 84-85, 356, because it eliminates or minimizes instrumentation in the woman's uterus, keeps any necessary instrumentation as low in the uterus (i.e., as close to the cervix) as possible, *App.* 26, 84-86, 412, and minimizes the risk of sharp bone fragments causing internal injuries. *App.* 10, 337. *See also App.* 446, ¶ 42. As one physician testified, the D&X approach is an "opportunit[y] . . . to provide an easier, less traumatic procedure for the woman and to . . . provide overall a safer procedure." *App.* 27-29.

The testimony also shows that sometimes an induction abortion does not proceed smoothly; patients labor and experience pain for extended periods of time, but do not expel the fetus. "So we've learned that it's necessary to intervene at some point, 24 to 30 hours, if the fetal expulsion has not occurred." *App.* 399-40; *see also App.* 84-85. These interventions are also necessary if the patient begins to bleed heavily or to develop an infection. If a patient is actively bleeding, the physician must evacuate the uterus in order to stop the bleeding; and if an infection develops, the longer the patient delays, "the worse her condition will become." *App.* 341. In these circumstances, completing the induction using one of the techniques used to complete a D&X "definitely [affords] a positive medical benefit," *id.*; it "is a potentially life-saving and certainly [a] health-saving maneuver." *Id.* at 342. If a physician was forced to wait for the complete expulsion of the fetus, that "would actually lead

to an increased risk of complications . . . it would be not . . . to the advantage of the patient." *App.* 86.[7]

All five physicians who testified for the plaintiffs testified that they had performed or set-out to perform abortions that the Seventh Circuit ruled could be constitutionally banned. All five testified to having done so when they believed that method was medically preferable for the particular patient involved based on, among other considerations, gestational age, the manner in which the fetus presents itself, the dilation achieved in relation to the size of the fetus, and the orientation of the uterus. *App.* 10-11, 20-21, 106, 129, 132-33, 173, 342-43.

Moreover, among the exhibits admitted into evidence in *Doyle* were:

- The American College of Obstetricians and Gynecologists' (ACOG) Statement on Intact Dilatation and Extraction (Jan. 12, 1997), which includes the conclusion that "for some women [the D&X procedure] may be the safest procedure." *See App.* 452-52.

- A Report of the Board of Trustees of the American Medical Association (AMA) stating that the D&X minimizes uterine or cervical perforation, and may be preferred for hydrocephalic fetuses and fetuses with other anomalies incompatible with life. *See App.* 452.

- A newly published medical textbook, Maureen Paul, M.D., et al., *Clinician's Guide to Medical and*

7. *See also App.* 15 (discussing medical risks to waiting for entrapped skull to pass cervix during D&E).

Surgical Abortion (1999), that discusses the procedure as one approach to surgical abortion after the first trimester.

- The text of the chapter "First and Second Trimester Abortion" from the medical text, David Nichols, M.D., et al., *Gynecologic, Obstetric, and Related Surgery*[8] (2d ed. 1999), that discusses the D&X as a variation of the D&E for abortions after 20 weeks of pregnancy.[9]

This cumulative evidence led the *Doyle* district court to make explicit findings of the medical benefits of the D&X. The district court found that the D&X is quicker and easier after 18 weeks from the first day of the woman's last menstrual period, and involves fewer insertions of instruments into the uterus. This results in a reduction in the amount of bleeding, the amount of time a patient is subject to anesthesia, and the risk of uterine perforation. *Doyle*, 44 F. Supp. 2d at 979.

Not only was there significant evidence in the record about the benefits of the D&X approach for many patients based on the manner in which the abortion proceeds, there was also detailed evidence about specific cases and specific medical circumstances in which the witness considered the D&X approach to be preferable for a patient based on the woman's health or a preexisting medical condition, or a fetal anomaly.

- Plaintiff Broekhuizen testified about three specific cases he had encountered within the preceding few

8. This text had not been published at the time of the *Doyle* trial; however, the text of the chapter was admitted into evidence.

9. *See also Hope*, at 882-85 (dissent).

years in which he began the procedure using the D&X approach because he believed it was the best approach from the perspective of his patients' health. In two of the three cases, the fetus spontaneously expelled during the procedure; in the third case, involving a severely hydrocephalic fetus, Broekhuizen completed a D&X procedure.[10] *App.* 79-83, 455, ¶¶ 104-05, 107-08 (describing three cases). He testified that in his practice involving high risk pregnancies, if he were denied access to the D&X approach, "[he] would find [him]self in more situations . . . where [his] only alternative would be to do a cesarean section or a hysterotomy, a major surgical procedure with increased morbidity and mortality for the mother." *App.* 110-11.

- Dr. Stubblefield, an expert witness, testified both about a specific case he had encountered where he also undertook the D&X approach because he believed it was the best approach from the perspective of his patient's health, and about medical situations generally where he believed the D&X could be the preferred approach. *See App.* 341-45 (discussing medical situations, generally) and *App.*

10. The district court dismissed this testimony by noting that in two of the three cases discussed by Broekhuizen the fetus delivered spontaneously without his having to collapse the skull, and by disagreeing with Broekhuizen's judgment about how to have proceeded in the third case. *Doyle*, 44 F. Supp. 2d at 981. This reasoning is not sustainable. The relevant facts are that in each case Broekhuizen made a rational professional judgment that the D&X was the medically preferable method to end the pregnancy and preserve his patient's health.

348-50 (describing actual case).[11] He testified that in these complicated circumstances, the D&X offers women a "positive medical benefit preserving the health, possibly preserving the life." *App.* 342.

- Dr. Haskell, also an expert witness, testified about three specific medical conditions — uterine scars, uterine fibroids, and didelphis or bilobe uterus — where he believed the D&X would be medically preferable from the perspective of the woman's health. *App.* 19 (describing medical situations).[12]

The majority in *Hope* ignored the district court's findings of the medical benefits of the D&X, and characterized plaintiffs' evidence as nothing more than "unelaborated avowals" that fails to "identify any concrete circumstance," and lacks "specifics." *Hope*, 195 F.3d at 872. But, as shown above, the plaintiffs' testimony was hardly unelaborated avowals. Rather, it was quite specific and concrete. Moreover, it was entirely consistent with the medical wisdom of the ACOG statement; there are circumstances where the D&X approach will be the best approach to protect a woman's health.[13]

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11. The district court opinion completely overlooks this testimony.

12. The district court opinion also completely overlooks this testimony.

13. The State of Wisconsin in its *amicus* brief in support of appellants, as did the district court, seeks to undermine the testimony of Drs. Broekhuizen and Stubblefield by pointing-out that neither of the hospital residency programs they supervise trains residents (Cont'd)

The Seventh Circuit also noted the district court's statements that no physician would testify "unequivocally" that the D&X is safer; that one plaintiff (Broekhuizen) testified that further study was desirable; that another plaintiff (Smith) testified that he had never encountered a situation where the D&X would be the best procedure; and that one of the plaintiffs' expert witnesses (Haskell) testified that the D&X was never medically necessary to save the life or preserve the health of the woman. *Hope*, 195 F.3d at 872.

The Seventh Circuit is correct that all of the witnesses agreed that a prospective, peer-reviewed comparison of D&X to alternative methods was desirable. But none of the plaintiffs' witnesses suggested that a criminal ban is necessary until such a study is done. And, it would certainly be unprecedented to use the criminal laws to prevent doctors from using newly developed medical techniques merely because they had not yet been subjected to peer-reviewed study. Indeed, Dr. Stubblefield, one of this country's leading researchers on abortion safety, characterized the available studies as "pretty good evidence" and "a good beginning."

(Cont'd)
in the D&X approach. *Amicus Br. of the State of Wisconsin* at 20 & 23; *Doyle*, 44 F. Supp. 2d at 980. Both physicians explained why this is so at trial. Resident are trained to perform D&Es only to 17 weeks. After that point, D&Es become more difficult and it is not reasonable to undertake to train residents in this more difficult procedure. *App.* 326. The D&X, "a briefer procedure . . .with less need for instrumentation within the uterus," is generally beneficial only at point later than 17 weeks. *App.* 342-43. However, a physician cannot undertake a D&X unless he is capable of converting to a D&E if necessary. *App.* 60-61. Thus, since the resident programs only provide D&Es to 17 weeks, they do not offer or train residents in the D&X.

App. 346-47.[14] Dr. Broekhuizen (who, like Dr. Stubblefield, was the Chair of a large medical center's OB/GYN Department) testified that he hoped for published peer-reviewed studies in the future, but he also testified that he was not "troubled" by the absence of peer-reviewed published studies and that he was comfortable basing his opinions and adjusting his practice based upon his personal experience and the available information. *App.* 100, 105-06. Further, he noted, "when it comes to new procedures there [are] always . . . a couple of years before one will find information in peer review journals." *App.* 100. *See also Planned Parenthood v. Doyle*, 162 F.3d 463, 468 (7th Cir. 1998). These statements are professional endorsement of the safety of the D&X, tempered by candid acknowledgment that further study is desirable. They are neither equivocal as to the safety of the D&X, nor do they support a ban of the procedure to protect maternal health.[15]

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14. Dr. Stubblefield also regarded the available studies as akin to peer-reviewed publications because they had been reviewed by a panel of their professional peers and chosen as sufficiently meritorious for presentation at a professional meeting. *App.* 428-29, 433.

15. The district court also cited the fact (which *amici* acknowledge) that physicians do not routinely use the D&X and more typically use the D&E as evidence of equivocal support for the procedure. *Doyle*, 44 F. Supp. 2d at 980. Plaintiffs make medical decisions on an individualized basis; as Dr. Haskell, who pioneered the D&X approach, testified: "I evaluate each patient on an individual basis. It depends on the amount of dilation that the woman has, her actual weeks of gestation, the presenting part, the size of the fetus, and a number of other factors go into the decision." *App.* 11. This is the essence of quality professional care, and is consistent with this Court's holdings that physicians must be given

(Cont'd)

The statement about Dr. Smith mischaracterizes his testimony and illustrates the danger of the lack of clarity concerning what is a D&X. *See supra* at 7. Dr. Smith, indeed, did testify that he had never encountered a situation where he thought that the D&X, *as defined by ACOG*, was medically preferable. *App.* 148. However, while he has never performed an abortion that exactly fit the ACOG definition of the D&X, *App.* 131, "many times" he has extracted a fetus intact until the head was at the cervix and then crushed the skull to complete the extraction because doing so was preferable for the patient. *App.* 128-29. *Hope* would allow the states to construe their statutes to include this method as among those banned. *Hope*, 195 F.3d at 861-62, 865. Thus, Dr. Smith has "many times" performed a D&X abortion which the *Hope* majority views as within the permissible reach of the Wisconsin statute.

The Seventh Circuit's reference to Dr. Haskell's statement that the D&X is never medically necessary exploits confusion about the precise meaning of that term, resulting in a mischaracterization of the record. Plaintiffs' witnesses all testified that, to a physician, the phrase "medically necessary" refers to a particular outcome, *e.g.*, it is medically necessary to terminate this pregnancy. They further testified, however, that, if medical necessity refers to the method that poses the least risk to the woman's health, then D&X is often medically necessary. *App.* 21. *See also App.* 25, 84, 106.

(Cont'd)
the room necessary to make individual determinations in order to preserve the health of each woman. *See infra* at 18. The fact that physicians proceed on a case-by-case basis, and thus do not routinely use the D&X cannot be fairly characterized as equivocation or a reason to justify banning that method of abortion in the instances when the physician does consider it preferable.

Although the *Hope* court did not discuss these "findings," the *Doyle* district court also discussed what it characterized as "risks" associated with the D&X approach: (a) delay of an additional 24 hours in order to achieve greater dilation; (b) the risks of ruptured membranes or infection that are created by the delay; and (c) the risk of future cervical incompetence posed by the greater dilation supposedly caused by the D&X. *Doyle*, 44 F. Supp. 2d at 979. None of these findings are supported by the record.[16]

On the question of delay in order to increase cervical dilation, the testimony showed that, in the ordinary course, "dilation determines the technique . . . technique does not determine dilation." *App.* 12. Women respond differently to the dilation process and fetuses often turn out to be smaller (or larger) than expected. *App.* 84-85,164. Thus, frequently, where there is more rapid dilation or a smaller fetus, there is the "opportunity," *App.* 12-13, to attempt an intact extraction or a D&X. Where there is not adequate dilation to attempt an intact extraction or a D&X, then the physician must make a decision, based on a variety of variables, whether to undertake a dismemberment D&E or to delay the procedure to obtain further dilation. *App.* 164-65, 84-85.

On the issue of infection, there simply was no testimony of such a risk. There was, however, ample testimony that

16. The Seventh Circuit cited two articles whose authors "believe the D&X procedure to be more hazardous." *Hope*, at 872. As the dissent points out, neither of these articles is a "scientific" article. One (Sprang and Neerhof) was in the nature of commentary in a section of the Journal of the American Medical Association captioned "controversies," and focuses on ethical issues. The other (Romer) is a non-medical paper written by a pro-life activist and focuses on saving rather than aborting viable fetuses. *Id.* at 884. We add that the latter article was not even part of the record.

the D&X poses no increased risk of infection. *App.* 21, 96, 107-08, 354.

On the issue of future cervical incompetence from increased dilation, the State's witness passingly mentioned that "older European literature" indicated a risk from increased cervical dilation of future cervical incompetence. *App.* 202. However, several other witnesses testified that there is no evidence of a risk to the cervix from increased dilation as currently done in the United States. They testified that broad studies[17] of the sequelae of abortion, which included D&Es using laminaria through about 20 weeks, have found no evidence of such a risk and they knew of no evidence to the contrary for later abortions. *App.* 354-55. *See also App.* 11-13, 89-90.

Hope simply mischaracterized the record in the Wisconsin case when it asserted that the issue of whether the D&X approach is ever preferable from the perspective of a woman's health was never seriously contested. To the contrary, the record demonstrates that the D&X approach is frequently medically preferable for women seeking abortions after approximately 18-20 weeks gestation because it poses fewer medical risks than the alternatives, and that the D&X is also medically preferable for women seeking abortions under complicated circumstances relating either to other health conditions or fetal anomalies.

17. Dr. Stubblefield has participated in some of these studies. *App.* 355.

2. The Applicable Legal Standard Requires the State To Establish That the Statute Is Necessary to Protect Maternal Health, and the Statute Must Allow Physicians the Room to Make Medical Judgments Based on the Particular Circumstances of the Individual Patient.

The majority in *Hope* held that when safe methods of abortion are legal, it is permissible to ban another method. *Hope*, at 871. The *Hope* majority also held that such a ban need not contain an exception to protect a woman's health because legislation can regulate procedure by procedure without allowing for "case-by-case 'health exception[s].' " *Id.* at 873. Further, *Hope* viewed the legal question before it as whether bans on the D&X method "pose hazards to maternal health," and whether "interference with the operation of the state laws can[not] be justified on the ground that the D&X procedure is necessary to protect women's health." *Id.* at 873.

These holdings ignore what the Tenth Circuit has correctly characterized as the "unifying thread" of this Court's abortion jurisprudence, *Jane L. v. Bangerter*, 61 F.3d 1493, 1504 (10th Cir. 1995), *rev'd in part on other grounds sub nom.*, *Leavitt v. Jane L.*, 518 U.S. 137 (1996), that in any abortion regulation a woman's health be paramount and that the physician be given the room he needs to exercise his professional judgment consistent with that mandate. *Thornburgh v. Am. College of Obstet. & Gyn.*, 476 U.S. 747, 768-69 (1986) ("maternal health [is] the physician's paramount consideration," and even post-viability, abortion restrictions cannot force a woman to "bear an increased medical risk"); *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (maternal health depends on physician discretion to "determin[e] how any abortion is carried out"); *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 427 (1983).

Instead, *Hope* indulges a blanket presumption that for all women in all circumstances — in spite of the voluminous testimony of five physicians to the contrary and the statements of both ACOG and the AMA — the D&X is never a safer or medically appropriate or medically necessary procedure. This nullifies the principle that is both rooted in this Court's jurisprudence, and that underlies the practice of medicine, that physicians must be accorded the discretion and room to make judgments according to individual evaluations of a particular patient's circumstances. As Dr. Broekhuizen, one of the plaintiffs, testified, no procedure is without risk, and different risks balance-out differently and lead to different decisions for different patients. *App.* 89-90. *Hope* substitutes instead a blanket medical judgment that it imposes on all women in all situations, and that it enforces by threat of sending the woman's physician to prison for the remainder of his life.

Further, in evaluating a previability ban on a method of abortion, the relevant question is not the one posed by *Hope:* namely, whether the ban is likely to *harm* the health of pregnant women. Consistent with this Court's precedent, the applicable question is whether the ban is necessary to *promote* the state's legitimate interest in women's health. *See Planned Parenthood v. Casey*, 505 U.S. 833, 878 (1992) (inquiry is whether the regulation "further[s] the health or safety of a woman seeking an abortion"); *Planned Parenthood v. Danforth*, 428 U.S. 52, 76 (1976) (determinative question is whether restriction " 'reasonably relates to the preservation and protection of maternal health.' ") (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973)).

The evidence in *Doyle* does not approach meeting that standard. At best, if a court were to regard Wisconsin's single witness as credible — a dubious conclusion[18] — the record would, from the perspective most charitable to the State, establish a professional disagreement about the advisability of the D&X method in some medical circumstances. This hardly meets the State's burden of establishing that the Act is necessary to protect maternal health. *Doe v. Bolton*, 410 U.S. 179, 195 (1973) ("State must show more than it has in order to prove" maternal health interest); *City of Akron*, 462 U.S. at 430-31 (regulations upheld only after "State met its burden of demonstrating" regulations furthered maternal health interest).[19]

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18. *See Hope*, 195 F.3d at 882-84 (dissent) (describing Wisconsin's sole witness as "the dubious Dr. Giles . . .").

19. *Cf. City of Richmond v. Crosson*, 488 U.S. 469, 494-95, 500 (1989) (discussing importance of "factual basis" and " 'strong basis in evidence' " for racial classifications); *Wittmer v. Peters*, 87 F.3d 916, 918 (7th Cir. 1996) (need to substantiate, not merely assert, need for racial classification).

CONCLUSION

Amici urge this Court to affirm the holding of the Eighth Circuit.

Respectfully submitted,

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